



New Hampshire Medicaid Fee-for-Service (FFS) Program

Prior Authorization/Non-Preferred Drug Approval Form

GLP-1 Agonists

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH:

GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER:

FAX NUMBER:

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of a type 2 diabetes mellitus? Yes No

If no, provide diagnosis: _____

2. Will the therapy be used as an adjunct to diet and exercise? Yes No

3. Has the patient had prior use of an oral anti-diabetic drug? Yes No

If yes, provide treatment and dates: _____

If no, provide contraindication or adverse effect: _____

4. Are there any other comments, diagnoses, or medication trials that would be important to this review? Yes No

Provide details: _____

(Form continued on next page.)



New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form
 GLP-1 Agonists

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

Allergic reaction. **Describe reaction:**

Drug-to-drug interaction. **Describe reaction:**

Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**

Age specific indications. **Provide patient age and explain:**

Unique clinical indication supported by FDA approval or peer reviewed literature. **Explain and provide a reference:**

Unacceptable clinical risk associated with therapeutic change. **Please explain:**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____